STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155167	A. BUILDING _____ B. WING _____	C 02/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE NORTH	**11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigaitonof Complaint IN00143034. Complaint IN00143034-Unsubstantiated due to lack of evidence Survey Dates: February 6th, 2014. Facility number: 000084 Provider number: 155167 AIM number: 100284600 Survey Team: Tom Stauss, RN, TC Karina Gates, Generalist Census Bed Type: SNF: 39 SNF/NF: 67 Residential: 85 Total: 191 Census Payor Type Medicare: 28 Medicaid: 50 Other: 113 Total: 191 Sample: 3 Westminster Village North was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regards to the Investigationof Complaint IN00143034. Quality review completed on Febuary 11, 2014, by Janelyn Kulik, RN.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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